UNIVERSITY OF CALIFORNIA SAN FRANCISCO
SCHOOL OF MEDICINE

**Application for Adult Echocardiography and Advanced Imaging Programs 2025-2026**

Director of Echocardiography Fellowship Program:
**Neal Shah, MD, FACC**
Assistant Professor of Medicine

RETURN COMPLETED APPLICATION TO:


Michael Stover
Associate Fellowship Coordinator
(415) 514-7288
michael.stover@ucsf.edu

or

Salina Gu
Cardiology Fellowship Programs Manager
(415) 502-1115
salina.gu@ucsf.edu


**PLEASE TYPE**

Please review the program qualifications at https://ucsfhealthcardiology.ucsf.edu/education-training/fellowship-programs/echocardiography-and-advanced-imaging-fellowship-programs and indicate the program you are applying to below:

- ☐ Advanced Echocardiography
- ☐ Advanced Non-Invasive Cardiovascular Imaging
- ☐ Echocardiography Training

Name_____ Gender_____
Last First Middle

Email Address_____ Date of Birth _____

Telephone Numbers: Cell_____ Alternate _____

Work Mailing Address: _____

Home Mailing Address: _____

Licensed to practice in Medicine in State (s) of _____ License No_____ AAMC ID_____

**USMLE SCORE:**

_____ _____ _____
Part 1 Part II Part III

Are you a Foreign Medical Graduate? ☐ Yes ☐ No If Yes, do you have a ECFMG certificate? ☐ Yes ☐ No

Certificate Date_____ Certificate Number_____

Will you need VISA Sponsorship for fellowship? ☐ Yes ☐ No If yes, list VISA type:_____

Proof of U.S. citizenship or eligibility for U.S. employment will be required upon hire in accordance with regulation established pursuant to the Immigration Reform and Control Act of 1986.

Is funding from an outside source available? Source and amount of grant_____

**EDUCATION**

Premedical/preosteopathic_____ Dates_____ Degree_____

Other_____ Dates_____ Degree_____

Medical/Osteopathic_____ Dates_____ Degree_____

Internship_____ Dates_____ Degree_____
Hospital Program Director

**RESIDENCIES**

_____ Dates_____ Degree_____
Hospital Program Director

_____ Dates_____ Degree_____
Hospital Program Director

**FELLOWSHIPS**

_____ Dates_____ Degree_____
Hospital Program Director

_____ Dates_____ Degree_____
Hospital Program Director

**LANGUAGE SKILLS OTHER THAN ENGLISH** (list languages and place an X in the appropriate area)

Language_____ Language_____

| | Excellent | Good | Fair | | Excellent | Good | Fair |
|---|---|---|---|---|---|---|---|
| Read | ____ | ____ | ____ | Read | ____ | ____ | ____ |
| Speak | ____ | ____ | ____ | Speak | ____ | ____ | ____ |
| Understand | ____ | ____ | ____ | Understand | ____ | ____ | ____ |

**PREVIOUS EMPLOYMENT** (professional or scientifically related)

Place_____ Dates_____

Duties_____

_____

Place_____ Dates_____

Duties_____

_____

Scholastic Societies_____

Honors and Awards_____

**CAREER GOALS AND PROFESSIONAL PLANS**: (please attach CV)

Describe career goals or professional plans for the future. Why have you chosen a career in echocardiography? What are your clinical and research objectives? What are your plans after completion of fellowship training? (Please use the space below or attach a separate personal statement)

_____

_____

_____

_____

_____

**REFERENCES**

Provide (3) three letters of reference. Note: Preference is to receive directly from your references.

1. _____
   Name Title Address

2. _____
   Name Title Address

3. _____
   Name Title Address

**ETHNIC BACKGROUND:** (please check one or more that apply below)

- ☐ American Indian or Alaskan Native
- ☐ Hispanic, Latino or of Spanish Origin
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ Asian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Indian
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian / Hmong
- ☐ Pakistani
- ☐ Taiwanese
- ☐ Vietnamese
- ☐ Other Asian _____
- ☐ Decline to answer

## PRIVACY NOTIFICATION STATEMENT

The information collected is used to satisfy the educational mission of the University and its legal obligations, including determination of eligibility, assessment, and evaluation of professional qualifications.

With the exception of the Affirmative Action data, all information requested is mandatory. If the information is not provided, the application will be deemed incomplete and not considered by the Program. The information you provide will be reviewed by the Departmental Residency selection committee and may be released pursuant to applicable Federal or State law. The privacy of your file will be the responsibility of the Department.

Individuals have the right to review their own record in accordance with the information Practices Act and University policy. Information on these policies may be obtained from the training Program to which you have applied and where your file is maintained.

I hereby authorize representatives of the School of Medicine to contact any of all of my former employers, educational institutions attended, or other persons or organizations determined to have information relevant to my application for clinical training. I further consent to such persons and organizations releasing relevant information to the School of Medicine, notwithstanding that it might otherwise be confidential. I understand that any information obtained by the School of Medicine will be treated as confidential personal information. I hereby certify that I have read and understood all statements and questions on this application and that my responses are true and complete to the best of my knowledge. If employed, I understand that falsification of this record may be considered cause for my termination.

**Signature of Applicant** **Date**